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Original Research Article

Empowering street food vendors on nutrition and healthy cooking practices in Urban Bengaluru: a mixed-methods evaluation of a community-based intervention

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ABSTRACT

Background: Street food vendors are central to India's urban food environment, providing affordable meals to millions. However, limited nutrition awareness and unsafe cooking practices among vendors contribute to poor dietary quality and increased risk of non-communicable diseases (NCDs). This study assessed the effectiveness of a structured nutrition and healthy cooking training program among street food vendors in Bengaluru, India.
Methods: A structured training program focusing on oil reuse, salt reduction and alternatives, balanced nutrition and NCD prevention was delivered through interactive, local-language sessions using pictorial tools and practical demonstrations. A community-based, mixed-methods study was conducted among 500 vendors across seven urban locations in Bengaluru. A sequential explanatory design combined quantitative pre- and post-intervention surveys with qualitative focus group discussions (FGDs) and field observations to assess knowledge gain, retention and practice adoption.
Results: The awareness of recommended daily salt intake (≤5 g/day) increased by 37% and knowledge of recommended oil intake (3–4 teaspoons/day) improved by 40%, post-intervention, Awareness of health risks associated with repeated oil reuse increased by 16–17%. Knowledge of healthier ingredient choices improved, with a 32% increase in recognition of wheat flour as a healthier alternative to refined flour. Approximately 80–85% of participants retained core training messages related to oil use, salt reduction and healthy cooking practices.
Conclusions: The training effectively improved nutrition knowledge and awareness among street food vendors. However, sustained behavior change will require periodic refresher trainings, economic and structural support and visible recognition mechanisms to reinforce healthy practices.

Keywords: Bengaluru, Community intervention, Healthy cooking, Non-communicable diseases, Nutrition education, Street food vendors

INTRODUCTION

Street food is an integral component of India's urban food environment, providing affordable, accessible and culturally familiar meals to millions of consumers each day.[1] In rapidly urbanizing cities such as Bengaluru, changing work patterns, migration and time constraints have increased reliance on street food for daily meals.[2] While street food supports livelihoods and food access, it often comes with nutritional and safety concerns. Vendors frequently prioritize taste, speed and affordability, leading to the widespread use of refined ingredients, excessive oil and salt and suboptimal cooking and hygiene practices. Consequently, street food

represents both an essential food source and a growing public health challenge. India's ongoing nutrition transition has coincided with a sharp rise in diet-related NCDs, particularly in urban areas. According to the National Family Health Survey (NFHS-5), 16–18% of urban adults are diabetic and nearly one in four has hypertension, while approximately one-third are overweight or obese.[3,4] Eating outside the home has also increased substantially, with the National Restaurant Association of India reporting a rise from 6.6 meals per month in 2018–2019 to 7.9 meals per month in 2023–2024.[2] This growing dependence on food prepared outside the home underscores the urgency of improving nutrition and cooking practices within the informal food sector.

Public health relevance

Street food vendors serve as critical intermediaries shaping urban dietary intake. Their ingredient choices, cooking methods and hygiene practices directly influence both nutritional quality and foodborne disease risk. Despite this role, most vendors operate with limited infrastructure, minimal formal training and restricted access to nutrition and health information. Studies from South India have documented low use of protective gear and poor hygiene awareness among vendors, while others have linked inadequate knowledge and unsafe practices to food contamination and health risks.[5,6]

Government-led initiatives, such as the Food Safety and Standards Authority of India (FSSAI)'s Clean Street Food Hub certification, have improved awareness of hygiene and regulatory compliance. However, these programs largely overlook nutrition education and healthy cooking practices. Existing training efforts focus primarily on cleanliness and licensing, with limited attention to ingredient quality, cooking methods or excessive use of salt, oil and processed additives. As a result, while food safety awareness has improved in some contexts, the nutritional quality of street food remains largely unaddressed.[7]

Existing evidence

Evidence suggests that education-based interventions can improve food safety knowledge and practices among informal food vendors. Studies in India have shown that targeted health education leads to measurable improvements in hygiene and food handling behaviors.[8,9] Research from Karnataka further demonstrates that vendor training programs can strengthen both knowledge and compliance with food safety norms.[6] However, two key gaps persist: most interventions show short-term impact due to limited follow-up and few integrate nutrition literacy or chronic disease prevention into training curricula. Globally, studies emphasize the need for low-cost, context-specific models that combine hygiene, nutrition education and behavioral reinforcement. Evidence from low- and middle-income settings indicates that culturally tailored training using visual tools, demonstrations and community follow-up improves knowledge retention and compliance.[1]

Rationale for the study

Bengaluru alone is estimated to have over 200,000 street food vendors operating across formal and informal settings.[10] Although mandatory food safety training was introduced by the Bruhat Bengaluru Mahanagara Palike (BBMP) and FSSAI in 2017, these efforts were disrupted during the COVID-19 pandemic and lacked a nutrition-focused component.[11] As urban food consumption rebounds post-pandemic, there remains a critical gap in structured, nutrition-oriented interventions for street food vendors.

To address this gap, Arogya World, in collaboration with NIDAN, a non-governmental organization working with marginalized and informal-sector communities developed a Street Food Vendor Training Module aligned with National Institute of Nutrition (NIN) and ICMR dietary guidelines. The intervention focused on reducing oil reuse, limiting salt intake, promoting healthier alternatives such as lemon and spices and increasing awareness of NCDs. Delivered in the local language (Kannada) using visual and practical methods, the program aimed to strengthen nutrition knowledge and bridge the gap between awareness and practice among urban street food vendors.

Objectives

This study aimed to evaluate the effectiveness of the nutrition and healthy cooking training program implemented among street food vendors in urban Bengaluru. Specifically, the study sought to assess the improvement in vendors' knowledge and awareness of nutrition, NCDs and healthy cooking practices following training. Examine knowledge retention and behavioral adoption through focus group discussions and field observations over time. Identify barriers and facilitators influencing the translation of nutritional knowledge into practice.

By combining quantitative and qualitative assessments, this research contributes to the limited evidence base on nutrition-focused vendor training in India. It provides a practical model for integrating nutritional education into urban food safety frameworks, aligning with India's national goals of reducing NCD prevalence through community-based interventions.

METHODS

Study design

The study was conducted between July 2024 and April 2025. A community-based, sequential explanatory mixed-methods design was adopted to assess the impact of a

structured nutrition and healthy cooking training program for street food vendors in Bengaluru, India. The design combined quantitative pre and post intervention surveys with qualitative Focus Group Discussions (FGDs) and field observations to provide a comprehensive understanding of knowledge gain, retention and behavioral adoption.

Study area and participants

The study was conducted in urban Bengaluru, Karnataka, a rapidly growing metropolitan city known for its vibrant street food culture. As part of the Arogya City Bengaluru initiative- Arogya World's city-level pledge to prevent NCDs through community-based interventions, nutrition and healthy cooking practices training was implemented for street food vendors operating in high-footfall urban areas. A total of 500 street food vendors were identified and enrolled through collaboration with NIDAN, a local vendor welfare organization. Vendors operated from fixed stalls, mobile carts and roadside setups across seven key localities: Anjanappa Gardens, Giripuram, Vinayaka Nagar, Majestic, Hegganahalli, Neelasandra and Shivaji Nagar. Inclusion criteria comprised adult vendors aged 18 years and above who had been operating continuously for at least six months prior to recruitment.

Intervention

The intervention was designed and implemented by Arogya World's MyThali program team. Training modules focused on reducing oil reuse, limiting salt and sugar intake, promoting healthier alternatives such as spices and lemon and raising awareness about NCDs. Nine in-person interactive sessions over the period of two months were delivered in Kannada using demonstrations, pictorial materials such as flyers which contained information on effects of high salt usage and salt substitutes, healthy cooking habits, harmful effects of reusage of oil and local examples to facilitate understanding. Each training session lasted approximately two hours, with follow-up visits for reinforcement.

Data collection

Quantitative data were collected through pre-intervention (n=376) and post-intervention (n=256) surveys using pictorial questionnaires assessing knowledge of salt, oil and cooking practices. Two FGDs were conducted six months post-intervention with 7–8 vendors each to explore knowledge retention, perceived barriers and behavioral changes. Seven field observations were conducted ten months later to objectively assess real-world practice adherence using a structured checklist.

Data analysis and ethical considerations

Quantitative data were analyzed descriptively to identify pre- post intervention differences, while qualitative data from FGDs were coded thematically. Observational data were triangulated to validate findings. Ethical approval was not required as no personal or identifying information was collected; however, verbal informed consent was obtained from all participants.

RESULTS

Socio-demographic characteristics

As Table 1 shows, a total of 500 vendors were enrolled in the program. Among them, 376 vendors completed the pre-intervention survey and 256 completed the post-intervention survey. The majority of the participants were females (82%), reflecting the large number of women engaged in informal food vending (Figure 1).

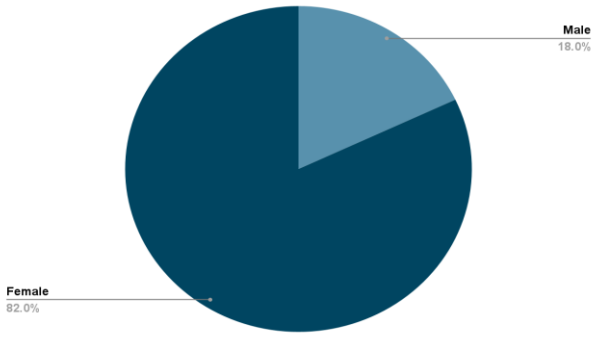

Figure 1: Gender distribution of street food vendors (n=376).

The age distribution showed the majority (37%) belonged to the age group of 40 years and above. In terms of education, over half of the respondents (52%) had completed only primary education. The low formal education level of the vendors was considered while designing the visual and interactive components of the training.

Types of food sold

Nearly 60% of vendors sold South Indian dishes such as idli, dosa, vada and meals; another 15.7% prepared North Indian foods while 14% specialized in fried snacks like samosa and bonda. A smaller portion of them sold chaats, sandwiches, juices, tender coconut and meat-based items such as biryani and kebabs.

The predominance of regional South Indian foods reflects local culinary preferences, but the presence of fried and high-salt foods highlights the need for nutrition education focusing on oil reuse, salt reduction and healthier cooking alternatives.

Awareness and knowledge of non-communicable diseases

Before intervention, none of the vendors were able to define or identify NCDs correctly. When prompted, only

25% could connect these to diet or unhealthy lifestyle factors. When asked about personal health conditions, about 75% of vendors reported not having any chronic illness, while the remaining quarter said they had been diagnosed with either diabetes or high blood pressure.

When asked about the perceived causes of NCDs, around one-third of the vendors attributed them to stress or tension, while a quarter mentioned unhealthy food habits, smoking or alcohol use as major factors. About 17% linked NCDs to irregular sleep patterns and 14% identified lack of physical activity as a possible cause. Nearly one-third of the participants, however, were unsure about what contributes to these diseases. Awareness about preventive measures such as maintaining a balanced diet and engaging in regular physical exercise was very limited and none of the vendors had ever participated in any training or workshop related to nutrition or healthy cooking before this program (Table 2).

Impact of the intervention on knowledge related to nutrition and healthy cooking practices

Knowledge about daily salt and oil intake

There was a notable improvement in awareness regarding the recommended daily limits for salt and oil following the intervention. Awareness about the advised daily salt intake (≤5 g or about one teaspoon per day) increased from 42% to 79% after the intervention, while knowledge of the recommended daily oil or fat intake (3–4 teaspoons per day) rose from 26% to 69% (Figure 2). These results indicate that the intervention helped vendors develop a clearer understanding of portion moderation and recognize the connection between excessive salt and oil consumption and health conditions such as hypertension and heart disease.

Figure 2: Increase in awareness of salt and oil intake post-intervention (%).

Awareness of harmful effects of oil reuse

The intervention significantly enhanced vendors' understanding of the health risks associated with reusing cooking oil. Awareness of the link between oil reuse and high blood pressure increased from 21% to 37%, while recognition of its association with heart disease rose from 33% to 45%. Similarly, awareness of the potential cancer risk increased from 11% to 27% and understanding of its connection to overweight and obesity improved from 40% to 50% (Table 3). These improvements demonstrate a stronger grasp among vendors of how everyday cooking practices can directly influence long-term health outcomes.

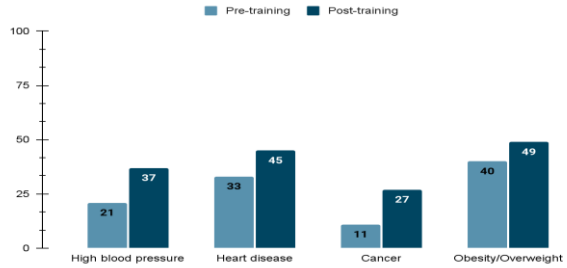

Figure 3: Knowledge on harmful effects of oil reuse (pre- and post-intervention) (%).

Knowledge of salt substitutes and healthier choices

Knowledge about natural alternatives to salt also showed improvement following the intervention. Awareness of using lemon or vinegar as substitutes increased from 59% to 70%, while awareness of using spices and herbs as flavor enhancers rose from 35% to 41%. However, understanding of hidden sources of salt in commonly consumed foods such as papads, pickles, sauces and chutneys remained relatively low, indicating the need to emphasize processed food awareness more strongly in future training sessions.

Awareness of healthy ingredients

Post-intervention data revealed a clear improvement in vendors' ability to identify healthier cooking ingredients. The proportion of vendors who recognized wheat flour as a healthier option than maida/refined wheat flour increased from 64% before intervention to 96% after the program. Similarly, awareness that coconut and groundnut oils are healthier alternatives to vanaspati/hydrogenated fat, palm oil rose from 89% to 99% (Table 3). These findings suggest that although a basic level of health awareness already existed among vendors, the intervention effectively reinforced and clarified evidence-based recommendations for healthier ingredient choices.

Post-intervention FGDs

Six months post intervention, two FGDs were held to assess knowledge retention and behavioral application. Approximately 80–85% of participants could recall the core messages related to oil reuse, salt reduction and healthy cooking practices. Several vendors reported

adopting positive changes such as switching from palm oil to sunflower oil, using pink salt instead of refined salt and maintaining greater hygiene in their cooking areas. A few vendors also indicated personal lifestyle improvements, such as applying the training lessons for themselves and their family members.

However, vendors identified multiple barriers to sustain practice change. The most frequently cited challenges included the higher cost of healthier oils, customer resistance to changes in taste and the absence of incentives for adopting healthier methods. A small group of vendors mentioned that while they briefly modified their cooking practices after the training, they reverted to previous habits due to affordability concerns. Despite these constraints, vendors expressed enthusiasm for continued training and suggested the inclusion of periodic health screenings during future sessions.

Table 1: Socio-demographic characteristics of street food vendors (n=376).

Variable	Category	Number (N)	(%)
Age (in years)	18–30	145	29.0
	31–40	170	34.0
	>40	185	37.0
Education level	Primary	260	52.0
	Secondary	210	42.0
	Graduate and above	30	6.0

Table 2: Awareness of perceived causes of NCDs (pre-intervention) (n=376).

Response	Number (N)	(%)
Stress/tension	128	34.0
Unhealthy eating/smoking/alcohol	94	25.0
Irregular sleep	64	17.0
Sedentary lifestyle	53	14.0
Don't know	37	10.0

Table 3: Improvement in knowledge on healthier ingredients and cooking practices.

Knowledge parameter	Pre-intervention (%)	Post-intervention (%)	% Change
Wheat flour healthier than *maida*	64.0	96.0	+32.0
Coconut/groundnut oil healthier than *vanaspati*/palm oil	89.0	99.0	+10.0
Use of lemon/vinegar as salt substitute	59.0	70.0	+11.0
Use of spices/herbs as salt substitute	35.0	41.0	+6.0

Monitoring visits

Ten months after the intervention, field observations were conducted across seven vendor sites to assess practical implementation. We observed noted that while knowledge retention remained high, consistent behavioral application was limited. A few vendors had reduced oil reuse and salt addition, but widespread practice change was hindered by financial pressures and ingrained routines. In most carts, visual reinforcements such as posters or MyThali flyers distributed during training were absent. 2-3% of vendors of vendors were observed using protective gear or visibly promoting healthier food preparation methods. Overall, the intervention achieved notable improvements in nutrition literacy and awareness, moderate changes in self-reported practices, but limited sustained behavioral modification in real-world settings. The findings suggest that while vendor-focused nutrition education can initiate meaningful learning, continuous engagement, economic feasibility and visual reinforcement mechanisms are essential for long-term impact.

DISCUSSION

This study aimed to evaluate the effectiveness of a structured nutrition education and healthy cooking training intervention for street food vendors in urban Bengaluru. Diet-related risks are among the leading contributors to non-communicable diseases in India, including cardiovascular diseases and diabetes.[12] The results demonstrate a statistically significant improvement in knowledge scores post-intervention, with a shift in awareness regarding the recommended intake of salt and oil, the health risks of reusing oil and the identification of healthier cooking alternatives. These findings reinforce prior evidence that community-based educational interventions can improve knowledge on food safety and nutrition among informal food handlers.[8,9,18]

One of the most promising outcomes of the intervention was the increase in awareness of recommended dietary guidelines, such as daily salt intake (from 42% to 79%) and oil consumption (from 26% to 69%). Awareness of health risks associated with oil reuse also improved, with vendors increasingly identifying links to hypertension, cardiovascular disease, obesity and even cancer. These knowledge gains are consistent with results reported by a study, who found that structured training improved vendor understanding of the consequences of poor food practices.[6] Similarly, another study observed significant improvements in hygiene practices and dietary awareness following health education sessions for food vendors in public institutions.[9]

While the study highlights encouraging knowledge gains among food vendors, it also brings to light the nuanced journey from awareness to sustained behavior change. Focus group discussions revealed that most vendors were able to recall and articulate key health messages even months after the intervention, an indication of the training's lasting impact on knowledge retention.[13,14,16]

Field observations, however, offered valuable insights into the real-world challenges of translating knowledge into consistent practice. Practices like reducing oil reuse or adopting salt alternatives are yet to become widespread. This aligns with findings by two studies, who also observed that while vendors are aware of safe food practices, their ability to implement change is often influenced by structural factors such as cost, limited time and established consumer expectations.[5,18]

In our study, vendors candidly shared that while they recognize the benefits of healthier practices such as steaming over frying, factors like affordability, customer preferences and deeply rooted cooking traditions continue to shape their choices. These insights present an opportunity to co-design solutions with vendors that are not only health-promoting but also practical, affordable and aligned with consumer tastes. This adaptive approach could help bridge the gap between awareness and action more sustainably.[15,17]

Notably, vendors also reported personal changes, such as adopting healthier cooking methods at home and greater attention to hygiene in their daily lives. This crossover between professional and personal behavior change is supported by previous research from a study, which emphasized that when nutrition education is localized, practical and delivered in native languages, it can influence both occupational and domestic domains.[6]

Customer responses played a critical role in vendor motivation. Some vendors who adopted healthier ingredients such as not using palm oil for cooking, noted increased trust and willingness among customers to pay more, suggesting that consumers are open to and even appreciative of such changes. This aligns with findings from a public perception study, where 70% of consumers favoured nutrition and hygiene training for vendors and indicated a preference for healthier food if available.[18] These findings highlight the potential for demand-driven reinforcement of healthy practices in street food settings.

However, the absence of sustained visual cues such as display flyers or branded aprons at food carts suggests a lack of post-intervention reinforcement, which likely contributed to limited translation of knowledge into consistent practice. This gap underscores the need for continuous engagement and environmental support, echoing principles of the Social Ecological Model (SEM), which highlights that behavior is influenced not only by individual knowledge but also by interpersonal, community and environmental factors. Reinforcing behavior through repeated visual prompts, social recognition and enabling environments is critical at multiple levels of this model.

These findings also align with the COM-B model of behavior change, which posits that sustained behavior requires a combination of Capability (knowledge and skills), Opportunity (supportive environments and resources) and Motivation (beliefs, attitudes and rewards). While the intervention clearly enhanced vendors' capability, the lack of environmental cues and incentives suggests limited opportunity for reinforcement and potentially, insufficient motivation to sustain new practices. These insights are supported by prior research in informal sector interventions, which stresses the importance of ongoing engagement, peer modeling and structural support to facilitate durable change.[16]

This integration of theoretical models with observed practice further supports the need for multi-component health promotion strategies that combine education, visual nudges, social support and recognition systems to foster long-term capacity and ownership among street food vendors.

The findings of this study must be interpreted in light of its limitations. The intervention's impact was primarily measured using immediate post-intervention surveys and short-term field observations. Longer-term behavioral assessments and randomized comparisons with untrained vendors could strengthen evidence on sustained change. Despite these limitations, the study contributes meaningful insights into the potential of nutrition training programs targeted at street food vendors to enhance their knowledge and influence food environments in urban India.

A major strength of this study lies in its mixed-methods design, which enabled triangulation of quantitative survey data with qualitative insights from FGDs and field observations. The inclusion of vendors across multiple urban zones enhanced representativeness and contextual validity. Additionally, the training's emphasis on local language delivery and pictorial materials improved accessibility for participants with limited literacy. However, the study has some limitations. Field observations, though valuable, provided only short-term insights. Longer-term longitudinal follow-ups would better capture sustainability of behavioral change. Despite

these limitations, the consistency between quantitative and qualitative data strengthens the credibility of the findings.

CONCLUSION

This study demonstrates that structured, customized, community-based nutrition education can substantially improve knowledge and awareness among street food vendors regarding healthy cooking practices NCD prevention. The intervention significantly enhanced understanding of oil reuse, salt moderation, healthier ingredient choices and the long-term health consequences of poor dietary practices. The high level of knowledge retention observed several months after the intervention underscores the effectiveness of culturally adapted, visual and participatory training approaches in improving nutrition literacy among low-literacy and informal worker populations.

Despite these gains in knowledge, the study clearly highlights a persistent gap between awareness and sustained behavior change. Economic constraints, customer taste preferences, habitual cooking practices and the absence of continuous reinforcement limited the consistent adoption of healthier practices at vendor stalls. These findings emphasize that one-time training interventions, while effective for knowledge transfer, are insufficient on their own to bring about durable behavioral change in informal food systems.

There is an urgent need for coordinated, nationwide action to address this gap. Scaling such interventions will require strategic partnerships between government agencies, public health institutions, non-governmental organizations working with the informal sector and organizations like Arogya World that specialize in behavior change communication. Additionally, greater investment through corporate social responsibility (CSR) funding and public health marketing is essential to strengthen vendor capacity, subsidize healthier inputs and support sustained engagement. Stronger policy integration and system-level strengthening, such as embedding nutrition education within existing food safety and vendor licensing frameworks are critical to ensuring long-term impact.

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REFERENCES

1. Yates PL. Food and agriculture organization of the United Nations. J Farm Eco. 1946;28(1):54-70.
2. Kulkarni SD, Kaur S, Ray A, Das JK. Measuring degree of serving organic food for restaurant supply chains in India. J Adv Man Res. 2026;16:1-20.
3. Ministry of Health and Family Welfare (India). National Family Health Survey (NFHS-5) 2019–21. Mumbai: IIPS. 2021.
4. Misra A, Khurana L. Obesity and the metabolic syndrome in developing countries. J Assoc Physicians India. 2008;56:163–70.
5. Rao P. Food safety knowledge and practices among street food vendors in South India. J Environ Health. 2016;78(9):24–30.
6. Biradar SS. Effect of health education on food hygiene practices among street food vendors. Int J Community Med Public Health. 2022;9:10315.
7. Reddy AA, Ricart S, Cadman T. Driving factors of food safety standards in India: learning from street-food vendors' behaviour and attitude: Reddy AA et al. Food Security. 2020;12(6):1201-17.
8. Anand D. Effect of health education on food hygiene practices and personal hygiene practices of food vendors. Int J Med Res Health Sci. 2016;5(8):118–23.
9. Kumar S. Impact of training intervention on food safety practices among street vendors. Int J Res Med Sci. 2021;9(5):10315.
10. Azim Premji University. State of Working India Report. Bengaluru. 2023.
11. Swinnen J, Vos R. COVID-19 and impacts on global food systems and household welfare: Introduction to a special issue. Agr Eco. 2021;52(3):365-74.
12. Afshin A. Health effects of dietary risks in India. Lancet. 2019;393:1958–72.
13. Michie S, van Stralen MM, West R. The behaviour change wheel: a new method for characterising interventions. Implement Sci. 2011;6:42.
14. Kelly MP, Barker M. Why is changing health-related behaviour so difficult. Public Health. 2016;136:109–16.
15. Story M, Kaphingst KM, Robinson-O'Brien R, Glanz K. Creating healthy food environments. Annu Rev Public Health. 2008;29:253–72.
16. Basheikh MA. Effectiveness of nutrition and food safety education interventions among street food vendors: a cross-sectional study. BMC Public Health. 2023.
17. Swinburn B. The global obesity pandemic: shaped by global drivers and local environments. Lancet. 2011;378:804–14.
18. Kamal A, Huda TM, Simi SM, Thomas ED. Determinants of street food hygiene practices and the effectiveness of interventions for vendors and consumers in low-and middle-income countries: protocol for a scoping review. JMIR Res Prot. 2026;15(1):68633.

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