Influence of Food Hygiene Perception, Price Fairness, and Vendor Trust on Purchase Intention Towards Indian Street Food

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Abstract **-**The Indian street food sector represents a vast informal economy consumed by millions daily, yet little primary evidence exists on what drives purchase decisions in this context. This study investigates how food hygiene perception, price fairness, and vendor trust—alongside health consciousness as an additional predictor—influence consumers' intention to purchase Indian street food. A quantitative descriptive cross-sectional study was conducted using a structured Likert-scale questionnaire (40 items across five constructs) administered online in March 2026. A total of 113 complete responses were retained. All five scales achieved acceptable internal consistency ($\alpha = 0.750–0.881$). Food hygiene perception was the strongest predictor of purchase intention ($r = 0.508$; $\beta = 0.306$), followed by price fairness ($r = 0.413$; $\beta = 0.195$), health consciousness ($r = 0.343$; $\beta = 0.195$), and vendor trust ($r = 0.464$; $\beta = 0.130$). The four-predictor regression model explained 38.6% of the variance in purchase intention ($R^2 = 0.386$). Perceived hygiene is the single most powerful determinant of street food purchase intention. Vendors and regulators should prioritise visible, observable hygiene practices.

Index Terms—*food hygiene perception; purchase intention; price fairness; vendor trust; health consciousness; Indian street food*.

I. INTRODUCTION

Ask anyone who grew up in an Indian city and they will tell you—some of their most vivid food memories are tied to a roadside stall, not a restaurant. A paper plate of golgappa on a humid evening. Biryani from the same vendor your father used to visit. There is something deeply habitual, even emotional, about how Indians relate to street food. It is not really a 'sector' in the way economists talk about sectors—it is more like an institution that happens to involve transactions.

What has changed over the last ten-odd years is that consumers have started asking more questions. Not loudly, not always consciously, but the questions are there: is this clean enough, am I being charged fairly, do I actually trust this person? These are not new anxieties—people have always had them. But rising health awareness, the aftermath of COVID-19, and increasing access to information have made consumers more attentive to what they are putting in their bodies and where it comes from.

This study grew out of an interest in that shift. Specifically, it tries to understand whether and how three things—how hygienic a vendor looks, whether the price feels justified, and how much personal trust a consumer has in the vendor—actually shape the decision to buy. A fourth variable, health consciousness, was added because it kept coming up in the pilot reading as something that seemed to influence how consumers weighed everything else. The data come from 113 respondents who filled out a structured questionnaire in March 2026, and the analysis uses correlation and regression techniques to pull apart what matters most and by how much.

A. Overview of the Sector

The Indian street food industry defies easy description. It is enormous—some estimates put it among the top informal employment sectors in urban India—and yet almost entirely untracked in any official statistical sense. Vendors are mostly self-employed, working without licences, often without running water, and sometimes without electricity after dark. The food they serve, however, is what millions of Indians eat every single day. Biryani, dosa, chaat, momos, vada pav—the list is long and varies by region in ways that no outsider fully appreciates.

FSSAI has been trying to clean things up, particularly through the Clean Street Food Hubs initiative, but actual enforcement is inconsistent at best. Most vendors are not going to suddenly produce food safety certificates. What they can do—and what consumers are actually responding to—is the visible stuff: whether the stall looks clean, whether the vendor handles food carefully, and whether the price is fair and consistent. These are the signals that substitute for formal quality assurance in this space, and they are what this study is really examining.

B. Vendor Profile

Respondents were not asked about a specific brand or chain. They were asked to think about whichever street food vendor they visit most regularly—meaning the 'vendor' in this study is different for every respondent. The food categories most prevalent in

the sample were biryani and rice dishes (38.9%), dosa and vada (21.2%), chaat and pani puri (16.8%), rolls and wraps (6.2%), and momos (5.3%). That spread matters because different food types carry different hygiene expectations, and the fact that the study captures this range makes the findings somewhat more generalisable across street food types.

C. Need for the Study

There is plenty of research on food safety in formal settings—restaurants, cafeterias, packaged foods. The literature on what actually drives purchase decisions in the informal street food economy is considerably thinner, especially in India. Most of the existing Indian work either focuses on microbial contamination (a supply-side concern) or looks at street food through a public health lens rather than a consumer behaviour lens. That gap has consequences: if policymakers do not know whether consumers are more deterred by hygiene, price, or trust concerns, they cannot design interventions that actually change behaviour.

D. Problem Statement

The practical tension this study tries to unpick is: the same consumers who say they worry about street food hygiene are also buying street food multiple times a week. They know, on some level, that hygiene standards at most stalls are not great—yet they keep going back. So what is actually driving the purchase decision? Is it that hygiene concerns get overridden by price and convenience? Or is it that even modest positive hygiene signals are enough to tip the balance? These are the questions this study addresses, with specific focus on the extent to which food hygiene perception, price fairness, and vendor trust independently predict purchase intention, and whether health consciousness changes how strongly these perceptions operate.

E. Objectives of the Study

Primary Objective: To examine the influence of food hygiene perception, price fairness, and vendor trust on purchase intention towards Indian street food.

Secondary Objectives: (1) To measure respondent perceptions across all five constructs using a validated Likert-scale instrument and describe the distribution of responses. (2) To test the bivariate association between each independent variable and purchase intention using Pearson correlation. (3) To assess the joint and relative predictive contribution of all four variables through multiple linear regression. (4) To explore whether health consciousness operates as a meaningful moderating variable or functions more as a direct predictor. (5) To characterise the demographic profile of the sample and contextualise the findings accordingly.

F. Scope and Limitations

The study covers adult consumers (18+) who had eaten Indian street food at least once in the six months before the survey. The data were collected online in March 2026 and 113 complete responses were retained. The sample is predominantly young and urban—about 79% of respondents fell in the 18–24 age bracket. The study measures stated intentions rather than actual behaviour, and it is cross-sectional. The sample skews young and educated, convenience and snowball sampling limit representativeness, and the instrument was not validated against an existing established scale.

II. LITERATURE REVIEW

Consumer intention to purchase food is not a simple thing to explain. People make food decisions quickly, often automatically, under the influence of hunger, habit, social context, sensory cues, and a dozen other factors that never show up in a regression model. What academic research can do is isolate specific variables and test whether they have a consistent, systematic relationship with purchase behaviour.

The theoretical backbone for this kind of research is usually Ajzen's (1991) Theory of Planned Behaviour, which argues that behavioural intentions are shaped by attitude toward the behaviour, subjective norms, and perceived behavioural control [1]. In the street food context, this maps onto attitude (do I think this food is safe and worth buying), social norm (do people like me eat street food), and perceived control (can I actually get to this stall easily). This study focuses mostly on the attitudinal side—hygiene, price, trust—because those are the factors that seem most modifiable and most under researched in the Indian context.

On hygiene, Worsfold and Griffith (1997) made the important point that consumers do not actually assess microbiological safety—they assess what things look like [14]. A surface that appears clean is treated as clean, regardless of what a petri dish might show. Bhatt and Bhatt (2015) confirmed in the Indian context that visible hygiene cues—vendor attire, surface cleanliness, food coverage—directly predicted purchase frequency [2]. Post-COVID, Liu et al. (2021) found that consumers are noticeably more attentive to these cues than before [8].

Price fairness is a construct that often gets underappreciated in street food research because the assumption is that street food is just 'cheap.' But Xia, Monroe, and Cox (2004) made a useful distinction: price fairness is not really about the absolute level of the price—it is about whether the price feels proportionate to the quantity, quality, and effort involved [15]. Namkung and Jang (2007) showed in restaurant settings that price fairness is an independent predictor of return visits, separate from food quality [11]. Bhattacharya et al. (2019) found similar patterns for Indian street food [3].

Vendor trust in street food settings is an interesting case because the normal cues for trust—brand reputation, certifications, institutional accountability—are largely absent. Moorman, Zaltman, and Deshpande (1993) defined trust in service contexts as confidence in a provider's reliability and integrity [10]. Delgado-Ballester and Munuera-Alemán (2005) showed that trust functions as a mediator between quality perceptions and loyalty [5].

Health consciousness entered this study as a potential moderator based on the literature linking it to more deliberate food safety evaluation. Michaelidou and Hassan (2008) found that consumers with higher health consciousness engage in more active pre-purchase information processing and apply stricter evaluative criteria to food choices [9].

III. MATERIALS AND METHODS

A. Type of Research

This is a quantitative descriptive study. The aim is to describe and quantify relationships between constructs rather than to test a causal intervention or build a commercial prediction model. The research questions call for measuring how strongly certain perceptions relate to a stated intention, and that is exactly what descriptive quantitative methods are designed for.

B. Data Collection

A structured questionnaire was built on Google Forms and distributed electronically through the researcher's academic and professional contacts in March 2026. Respondents were encouraged to forward it to others who qualified, creating a snowball effect. Out of all responses received, 113 were complete and usable. The questionnaire had three sections: demographic information, consumption frequency and food type preferences, and five Likert-scale constructs.

C. Measures

Each of the five constructs was measured with eight items on a five-point Likert scale ranging from Strongly Disagree (1) to Strongly Agree (5). Composite scores were computed by averaging the eight items for each respondent on each construct. Food Hygiene Perception (Q1–Q8) asked about preparation surface cleanliness, glove and hand hygiene, ingredient storage, utensil condition, and overall stall appearance. Price Fairness (Q9–Q16) covered perceived value, price-quality match, and pricing consistency. Vendor Trust (Q17–Q24) included trust in ingredient freshness, honesty, reliability, and genuine concern for customer health. Purchase Intention (Q25–Q32) asked about likelihood of purchasing, preference over other options, and intent to continue visiting. Health Consciousness (Q33–Q40) covered health awareness in daily food choices and pre-purchase hygiene evaluation habits.

D. Sampling

The sampling frame was defined as adults aged 18 or above, currently residing in India, who had consumed Indian street food at least once in the six months preceding the survey. A total of 113 responses were collected. Green's (1991) guideline for multiple regression—$N \geq 50 + 8m$—puts the minimum needed for this study at 82 [6]. The sample of 113 clears that threshold. Convenience sampling supplemented by snowball referrals was used.

E. Conceptual Framework and Hypotheses

The study's conceptual model positions Food Hygiene Perception, Price Fairness, and Vendor Trust as independent predictors of Purchase Intention towards Indian street food. Health Consciousness sits alongside these as a variable expected to moderate the relationship. Four formal hypotheses were derived:

H1: Food Hygiene Perception has a significant and positive influence on Purchase Intention towards Indian street food.

H2: Price Fairness has a significant and positive influence on Purchase Intention towards Indian street food.

H3: Vendor Trust has a significant and positive influence on Purchase Intention towards Indian street food.

H4: Health Consciousness significantly moderates the relationship between the three independent variables and Purchase Intention.

F. Validity of Instrument

Content validity was addressed by grounding each item in published literature. Cronbach's alpha was used to assess internal consistency: Food Hygiene Perception $\alpha = 0.843$, Price Fairness $\alpha = 0.833$, Vendor Trust $\alpha = 0.838$, Purchase Intention $\alpha = 0.750$, and Health Consciousness $\alpha = 0.881$. All five exceed the standard 0.70 minimum [12]. The instrument also shows reasonable discriminant validity.

IV. RESULTS

A. Demographic Profile

Table 1 presents the demographic breakdown of the 113 respondents. Of the 113 respondents, 65 were male (57.5%) and 48 were female (42.5%). The age breakdown was heavily skewed toward younger respondents: 89 (78.8%) fell in the 18–24 bracket, 20 (17.7%) in the 25–34 bracket, and just 4 (3.5%) were aged 35–44. Education levels were high: 62 respondents (54.9%) were undergraduates and 43 (38.1%) were postgraduates.

Demographic Variable	Category	Frequency (%)
Gender	Male	65 (57.5%)
	Female	48 (42.5%)
Age Group	18–24 years	89 (78.8%)
	25–34 years	20 (17.7%)
	35–44 years	4 (3.5%)
Education	Undergraduate (UG)	62 (54.9%)
	Postgraduate (PG)	43 (38.1%)
	Doctorate or above	6 (5.3%)
	10th/12th Standard	2 (1.8%)
Monthly Income (₹)	Below 15,000	22 (19.5%)
	15,001–30,000	26 (23.0%)
	30,001–50,000	18 (15.9%)
	50,001–1,00,000	29 (25.7%)
	Above 1,00,000	18 (15.9%)
Street Food Frequency	Daily	7 (6.2%)
	Several times a week	26 (23.0%)
	Once a week	22 (19.5%)
	A few times a month	37 (32.7%)
	Rarely	21 (18.6%)

Table 1: Demographic Profile of Respondents (n = 113)

B. Reliability Analysis

Cronbach's alpha was run on all five scales before any inferential analysis to check that the items within each scale were measuring the same underlying construct. Table 2 shows the results. Everything cleared the standard 0.70 threshold. Health Consciousness came in highest at 0.881. The Purchase Intention scale at 0.750 was the weakest.

Construct	No. of Items	Cronbach's Alpha (α)
Food Hygiene Perception	8	0.843
Price Fairness	8	0.833
Vendor Trust	8	0.838
Purchase Intention	8	0.750
Health Consciousness	8	0.881

Table 2: Reliability Statistics

C. Descriptive Statistics

Table 3 presents descriptive statistics for each construct's composite score, averaged across the eight items on a 1–5 scale. The hygiene perception mean of 2.877 is the number that stands out immediately—it is the only construct that sits below the scale midpoint of 3.0. Respondents, on average, lean toward disagreeing that their regular vendor maintains satisfactory hygiene. Yet their purchase intention mean is 3.329. Health consciousness came in at 3.576—the highest of all five constructs.

Construct	Mean	Std. Dev.	Min	Max
Food Hygiene Perception	2.877	0.679	1.00	5.00
Price Fairness	3.405	0.672	1.12	5.00
Vendor Trust	3.031	0.657	1.00	5.00
Purchase Intention	3.329	0.616	1.25	5.00
Health Consciousness	3.576	0.766	1.38	5.00

Table 3: Descriptive Statistics – Construct Composite Scores

D. Correlation Analysis

Table 4 shows the Pearson correlation between each independent variable and purchase intention. Hygiene perception tops the table at r = 0.508. All four correlations are statistically significant at $p < 0.001$ or better. The ordering—hygiene first (0.508), then trust

(0.464), then price (0.413), then health consciousness (0.343)—needs to be read carefully, as bivariate correlations do not tell you how much of each variable's effect is unique versus shared with the others.

Variable	Pearson r	p-value	Interpretation
Food Hygiene Perception	0.508	< 0.001	Moderate positive
Price Fairness	0.413	< 0.001	Moderate positive
Vendor Trust	0.464	< 0.001	Moderate positive
Health Consciousness	0.343	0.0002	Weak-moderate positive

Table 4: Pearson Correlation – Predictors vs. Purchase Intention

E. Hypothesis Testing

H1 – Food Hygiene Perception significantly and positively influences Purchase Intention. Supported. The correlation is r = 0.508 ($p < 0.001$) and the standardised beta in the regression is 0.306, making it the strongest predictor in the study.

H2 – Price Fairness significantly and positively influences Purchase Intention. Supported. r = 0.413 ($p < 0.001$), $\beta = 0.195$ in the full model. Price fairness contributes independently even after accounting for the other variables.

H3 – Vendor Trust significantly and positively influences Purchase Intention. Supported, but with a note. The bivariate correlation is a solid 0.464 ($p < 0.001$), but the regression beta drops to 0.130 once the other variables are in the model.

H4 – Health Consciousness moderates the relationships between the independent variables and Purchase Intention. Partially supported. Health consciousness is significantly correlated with purchase intention (r = 0.343, $p < 0.001$) and contributes positively in the regression ($\beta = 0.145$). However, formal moderation through interaction terms was not tested in this analysis.

F. Multiple Regression Analysis

Table 5 shows the results of the multiple linear regression with Purchase Intention as the dependent variable. The four predictors together explain $R^2 = 0.386$, meaning 38.6% of the variation in purchase intention is accounted for by this model. Food hygiene perception is out in front at $\beta = 0.306$. Price fairness and health consciousness are tied at $\beta = 0.195$ each. Vendor trust settles at $\beta = 0.130$ once the other variables are in the model.

Predictor Variable	Beta (β)	Relative Rank	Model R^2
Food Hygiene Perception	0.306	1st	0.386
Price Fairness	0.195	2nd (tied)	
Health Consciousness	0.195	2nd (tied)	
Vendor Trust	0.130	4th	

Table 5: Multiple Regression Results – Predictors of Purchase Intention

V. DISCUSSION

The gap between the hygiene perception mean (2.877) and the purchase intention mean (3.329) is the finding that deserves the most analytical attention. Respondents are—on average—mildly dissatisfied with the hygiene standards they observe at street food stalls. But they are still inclined to buy. What the regression tells us, however, is that within this population, the people who perceive better hygiene also report significantly higher purchase intention. Hygiene is not irrelevant—it is just that the threshold for refusal is higher than for mere dissatisfaction.

The trust story in the regression is one of the more technically interesting parts of the analysis. Trust's bivariate r of 0.464 seems to suggest it is nearly as important as hygiene. But once hygiene perception is in the model, trust's coefficient drops to 0.130. The most straightforward interpretation: trust and hygiene are measuring overlapping things in consumers' minds. When you trust a vendor, part of what you mean is that they seem clean and careful. This finding resonates with Delgado-Ballester and Munuera-Alemán (2005), who showed that trust functions as a mediator between quality perceptions and loyalty [5].

Price fairness holding up consistently across both bivariate and multivariate analyses is worth emphasising. Street food's value proposition has always rested on affordability, but this study suggests it is not just about being cheap—it is about feeling that the price is fair in relation to what you get. This distinction aligns with Xia, Monroe, and Cox's (2004) framework of price fairness as proportionality rather than absolute level [15].

The finding that health consciousness contributes directly to purchase intention ($\beta = 0.145$ in the regression) rather than solely moderating the effects of hygiene and trust deserves attention. In a sample of young, educated urban consumers who score highly on health consciousness (M = 3.576), this awareness appears to be an active purchase driver rather than a passive background

variable. This is consistent with Michaelidou and Hassan's (2008) argument that health-conscious consumers apply stricter evaluative criteria to food choices [9].

VI. CONCLUSION

The central finding of this study is fairly clean: among Indian street food consumers in this sample, how hygienic a vendor appears to be is the single strongest predictor of whether someone intends to buy from them. More than price, more than trust, more than how health-conscious the consumer is—perceived hygiene drives purchase intention. And it does so even in a sample where hygiene perceptions are, on average, below the scale midpoint.

This matters because it points to a real and tractable opportunity. The gap between what consumers want to see hygiene-wise and what they currently observe at street food stalls is wide enough to be both a problem and a lever. Vendors who close that gap—through visible, observable hygiene practices—stand to gain more consumer confidence and purchase intent than they might expect. For a sector that operates mostly on repeat patronage and word-of-mouth, that is not a trivial return on a relatively modest change in behaviour.

Price fairness and vendor trust are also real factors in the decision—not afterthoughts. Future research should include more demographically diverse samples, longitudinal designs to test hygiene interventions over time, formal moderation testing via interaction terms, and qualitative fieldwork to add texture to these survey findings.

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